AFC Urgent Care of San Diego
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Patient Authorization to Release Medical Records
Authorization for Use of Disclosure of Protected Health Information

Please complete the following information:
Patient Name: _____ DOB: _____

Address: _____ City: _____State: _____

Phone: _____ SSN: _____

I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information.

- ☐ All records, laboratory, pathology and x-ray reports
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Other: _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing the disclosure of this information.

These records are for services provided on the following date (s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____

Address: _____ City: _____ State: _____

Phone Number: _____ Fax: _____

The information may be used/disclosed for each of the following purposes:

- ☐ Patient request (only patient can check this)
- ☐ Continued care
- ☐ Payment/insurance
- ☐ Employment purposes
- ☐ Legal request
- ☐ Other: _____

The authorization shall expire no later than _____/_____/_____, or upon the following event_____ (whichever is sooner) and may not be valid for greater than one year from date of signature. I understand that after the custodian of records disclose my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

_____ _____
Signature of patient (or patients personal representative) **Date**

_____ _____
Printed name of patient or representative **Date**